NC MEDICAID MANAGEMENT INFORMATION SYSTEM+ (NCMMIS+) PROGRAM

Quarterly Report

to the

North Carolina General Assembly

May – July 2013

APPENDIX D – REPLACEMENT MMIS BENEFITS SUMMARY

State of North Carolina

Department of Health and Human Services

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The NCMMIS+ Program manages the implementation of comprehensive, DHHS enterprise-wide automated Medicaid systems with benefits that greatly exceed the capabilities of the current Legacy MMIS and ancillary systems, such as:

- Decision Support System (DSS);
- Surveillance;
- Utilization Review System (SURS); and
- Purchase of Medical Care Services (POMCS).

The **NCMMIS+ Program** includes:

- Replacement MMIS (the multi-payer claims processing system that will replace the Legacy MMIS);
- Reporting and Analytics (R&A) System; and
- Division of Health Service Regulation (DHSR) Business Process Automated System (BPAS).

The **Replacement MMIS** will have numerous advanced features to maximize the administrative efficiency and ease of use for:

- NC taxpayers;
- Recipients;
- Agency staff; and
- Healthcare providers.

New Systems Benefits for Stakeholders:

- **NC Taxpayer Benefits**
  - An estimated $165 million in systems' operating costs savings during the first five years for the Replacement MMIS;
  - Lower net Medicaid drug costs through the Supplemental Drug Rebate/Preferred Drug List (PDL) program. PDL is a list of preferred prescription medications based on clinical efficacy and safety, as well as costs to the Medicaid program. To date, the State has collected a total of $149.8 million in drug rebates from participating pharmaceutical companies for placing their drugs on the PDL. Additionally, a total of $410,956 has been collected by the State thus far in Health Choice Drug Rebates.
  - Cost avoidance for the Division of Prevention, Access and Public Health Services through the elimination of the largely manual POMCS system as a result of the improved sequencing, processing and payment of claims.

- **Medicaid Recipient Benefits**
  - Transparency of information about health care services and outcomes, facilitating a self-service model for access to information;
  - Improved healthcare access, including improved online communications;
  - Improved healthcare services; and
  - Improved healthcare outcomes for the most vulnerable citizens.

➢ DHHS Benefits

Cost Savings

- Redirected State staffing costs through automated business functions and efficiencies gained through the consolidation of functions, resources and systems, as well as business process streamlining;
- Increased State purchasing cost-reduction opportunities through a single integrated multi-payer system for State-sponsored health programs;
- Reduced claims payment errors;
- Improved accuracy in dispensing services, equipment, and drugs to program recipients;
- Easier, more timely and cost-effective system changes;
- Reduced operating and drug costs;
- Enhanced cost avoidance; and
- Improved waste, fraud, and abuse detection across programs since administrators can analyze multiple healthcare programs' utilization, billing, and coding patterns.

Functionality

- Automated business functions;
- Consolidated business functions, resources, systems, and processes;
- Increased ease of future system growth and alignment with:
  - Medicaid Information Technology Architecture (MITA),
  - National Provider Identification (NPI) taxonomy frameworks, and
  - Industry standard code sets;
- Improved information access and coordination of benefits across multiple agencies;
- Improved program administration, while improving services to providers; and
- Improved confidentiality protection, while providing information to those who need to know.

Early Implementation Operations

- <u>Enrollment, Verification and Credentialing (EVC)</u>
  - In April 2009, CSC implemented a sub-contracted proprietary EVC software system for the enrollment of Medicaid providers.
  - This implementation lifted the burden of provider enrollment from a totally manual system in the Division of Medical Assistance (DMA) Provider Services Unit to the fully-automated system run by CSC.
  - Provider Services staff is able to focus on policy and program oversight issues.
  - The EVC system, a temporary solution within the Replacement MMIS Project, will be replaced with a more robust provider enrollment subsystem that will be integrated with *NC Tracks*, also known as the Replacement MMIS, at Go-Live and realize the benefits of the new claims payment system.

EVC Statistics to Date:

- A total of 83,644 provider enrollment applications have been received from inception in April 2009 through July 2013;
- A total of 2,433 new provider enrollment applications were received in May and June of which 343 were completed. The reduced approval rate was caused by the systems freeze in mid June to prepare enrollment data for conversion to NCTracks. 1,011 applications were received in July.
- Average processing time to complete all application types was 14 business days in May and June.
- During the quarter, the EVC Call Center answered an average of 12,769 provider calls per month in May and June and 54,129 calls in July. The call volume increase in July was due to NCTracks Go-Live. Call volume was driven primarily by providers experiencing log in or other system issues.
- From October 2010 through July 2013, CSC has notified a total of 46,730 providers of the need to submit recredentialing forms, either electronically or via paper. This is a function that DMA's Provider Services was previously unable to address.
- Provider enrollment fees ($100 per enrollment) in the amount of $5,285,250 have been collected through July, 2013.

- <u>RetroDUR (Drug Utilization Review)</u>
  - Under the RetroDUR program, Medicaid paid claims data is used to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients, or patterns associated with specific drugs or groups of drugs and patterns of fraud and abuse.
  - RetroDUR activities have been moved from DMA, with collaboration from ACS and HP, to CSC's subcontractor, including recipient and provider profiling and ad hoc reporting.
  - The outcomes from this program have improved the quality of care for Medicaid recipients, improved compliance and adherence concerns, educated providers on the latest prescribing standards, and helped conserve program funds.

➢ **Health Care Provider Benefits**

- The Provider Web Portal provides a secure and convenient mechanism to complete, electronically sign, and submit initial provider enrollment applications, retrieve, view, and update enrollment information, and check the status of a new application, re-credentialing application, or enrollment change request.
- Providers are able to inquire about recipient eligibility for a single date or a span of dates, and can submit an online "mini-batch" to obtain eligibility information for up to 25 recipients in a single transaction.
- The new system allows the electronic submission of all claim types, including pharmacy claims for the Sickle Cell Program in the Division of Public Health.
- Providers receive electronic Remittance Advices.
- The automated pharmacy prior approval function enables an immediate response to a prior approval request submitted via secure website or fax/paper.

- The new system fully supportss Electronic Fund Transfers (EFT) of claims payments for the Division of Public Health.
- The Automated Voice Response System (AVRS) provides an enhanced and redesigned AVRS to more efficiently direct callers through the various options to obtain desired information.
- 24/7 Internet access and self-service features allows providers access to information without a Provider Relations Agent.
- Providers have online access to the Enhanced Pharmacy Program which includes NC Medicaid and Health Choice PDLs.
- Other Benefits include:
  - Improved access to online provider training, including access to online provider manuals;
  - Reduced payment errors;
  - Reduced administrative burden through paperless commerce;
  - E-Prescribing;
  - Improved cash flow; and
  - Improved communications and timelier responses to inquiries.

Provider Operational Preparedness (POP)

- The Department worked with various types of providers to educate and train them on the new Remittance Advice (RA) reports created by the Replacement MMIS.
- *POP* executed RAs in NC Tracks based on claims processed by the Legacy MMIS.
- Additionally, DHHS conducted a *POP* period beginning March 1, 2013, and continued through June 30, 2013. During this time, the same claims were processed through both the Legacy MMIS and the Replacement MMIS so that providers could compare payments from the two systems.
- A help desk staffed by the DHHS and CSC answered payment and processing questions throughout the *POP*. This extra level of provider education confirmed that the new system was processing claims according to the appropriate State policies, prior to the Replacement MMIS Go-Live.

International Statistical Classification of Diseases – 10th Revision (ICD-10)

The transition from *ICD-9* to *ICD-10*, a prerequisite for the electronic health record (EHR) in the Replacement MMIS, will provide the following benefits:

- Detailed information about *ICD-10* codes will help providers improve the quality of patient care.
- Detailed code sets make it easy for patients to understand the disease. This, coupled with improved information in the EHR and public health record (PHR), ultimately results in greater patient safety and better provider-patient relationships.
- Accurate payments, lower rejection rates, reduced administration cost, and improved revenue cycles directly link to better financials—a key success factor for evaluating investments made for *ICD-10*.
- *ICD-10* can also act as a catalyst for achieving “meaningful use” of EHR, a Centers for Medicare and Medicaid Services (CMS) requirement for Medicaid

Incentive Payment System (MIPS) funding to the provider, through more detailed patient information.

The **R&A System** will be closely linked with the Replacement MMIS, and will provide the following benefits not achievable through the Legacy MMIS, Decision Support System (DSS), and Surveillance Utilization and Review Subsystem (SURS):

- Improved waste, fraud, and abuse detection across programs;
- A centralized claims payment data repository with six years, rather than the current three years, of claims history;
- Access to claims payment data to a broader spectrum and number of DHHS staff in a secure environment that meets State and federal Personal Health Information (PHI) rules;
- User-friendly tools for monitoring and assessing trends in the delivery of health care, expenditures, and outcomes;
- More informed policy decisions about the programs DHHS administers;
- Improved guidance for prevention and intervention programs;
- Information for community and program planning;
- Access to market data from various sources for comparison of utilization trends for Medicaid and commercial programs; and
- Functionality to support the State Health Plan in a user-friendly and secure environment.

The **DHSR BPAS Project** reengineers business processes and provides the means for integrating workflows and data among the DMA, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH), and DHSR. The following are some of the benefits of the DHSR BPAS implementation:

- DHSR data is incorporated within the Replacement MMIS to enable optimal decisions and actions in a timely manner by the Medicaid Program;
- Information regarding the status of facility or program registration, license, and Medicare and Medicaid participation is electronically available to appropriate entities;
- Organizational knowledge loss due to attrition and other factors is prevented through a documented, repeatable, standardized, maintained, and automated business process system;
- A flexible system accommodates frequent legislative changes;
- Existing data from multiple sources is converted to a common and unified data source;
- Current business reporting needs are satisfied;
- Manual analysis, routing, redundant operations, and process cycles time are reduced.
- Online help and training facilities is provided;
- Support is provided for existing, new, or changed business models; and
- The need for temporary staffing is mitigated through standardized processes.

End of Appendix D